

4339

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 5 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

08974		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				08966			
1. DECEASED-NAME (Type or print) First Middle Last MAE Theresa BLANCHARD						2a. DATE OF DEATH Month Day Year June-3-69		2b. HOUR 12:30 M	
3. SEX Female		4. RACE White		5. DATE OF BIRTH May 28, 1890		6. AGE (In years last birthday) 79 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Talbot Md.			
10. CITY OR TOWN OF DEATH EASTON		11. NAME OF HOSPITAL OR INSTITUTION (If not in-hospital give street address) Memorial		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housework		12b. KIND OF BUSINESS OR INDUSTRY Home			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Caroline		13c. CITY OR TOWN Federalsburg		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 315 W. Central Avenue	
14. FATHER'S NAME First Middle Last (first name unknown) Baer		15. MOTHER'S MAIDEN NAME First Middle Last Eva (maiden name unknown)							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) No		16b. SOCIAL SECURITY NO. None		17. INFORMANT Address Mrs. Ann Flatten, Federalsburg, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thrombosis</u> 4339 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>21 May</u> , 19 <u>69</u> , to <u>3 June</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>2 June</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Thurston Harrison M.D.</u>		DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>3 June 69</u>			
22d. PHYSICIAN'S NAME (Type) THURSTON HARRISON		22e. ADDRESS Easton Maryland							
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE June 10, '69		23c. NAME OF CEMETERY OR CREMATORY Silverbrook		23d. LOCATION (City or Town) (County) (State) Wilmington, New Castle, Del.			
24. FUNERAL DIRECTOR ADDRESS Frampton Funeral Home, Federalsburg, Md				25a. REC'D BY REGISTRAR DATE JUN 9 1969		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

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4369

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MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print) <b>GIFFORD</b>			First Middle Last <b>CHARLES BOWDLE</b>			2a. DATE OF DEATH Month Day Year <b>6-8-69</b>			2b. HOUR <b>12</b> M	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>June 30, 1893</b>		6. AGE (In years last birthday) <b>75</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>TALBOT</b>			Md.	
10. CITY OR TOWN OF DEATH <b>EASTON</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Memorial</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>retired farmer</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Farm</b>			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Caroline</b>		13c. CITY OR TOWN <b>Federalburg</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>Corner Morris and Vernon Av</b>		
14. FATHER'S NAME First Middle Last <b>James BOWDLE</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Elizabeth (unknown)</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <b>NO</b>		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <b>219-34-3846</b>		17. INFORMANT Address <b>Calvin Blades, Federalburg, Md. Box 176 R.F.D. #2</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral vascular accident</b> <b>4369</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5-19-68</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <b>5-19-69</b> , to <b>6-8-69</b> , that (I) (we) last saw the deceased alive on <b>6-6-69</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>Stephen P. Carney</b>				DEGREE <b>M.D.</b>		ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		
22d. PHYSICIAN'S NAME (Type) <b>Stephen P. Carney M.D.</b>				22e. ADDRESS <b>Easton, Md. 21601</b>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>June 11, 1969</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Junior Order Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Preston Caroline, Md.</b>				
24. FUNERAL DIRECTOR <b>J. Livingston &amp; Son</b>				ADDRESS <b>Federalburg Md.</b>		25a. REC'D BY REGISTRAR <b>JUN 13 1969</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		

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THE STATE OF TEXAS

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Page 1 of 1

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
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08976				DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				08968				
1. DECEASED-NAME (Type or print)				First	Middle	Last	2a. DATE OF DEATH Month Day Year				2b. HOUR 1:45 P.M.	
JOHN SAMUEL BRIDGES							June 6, 1969					
3. SEX Male		4. RACE White		5. DATE OF BIRTH July 22, 1868			6. AGE (In years last birthday) 100 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Talbot County Md.					
10. CITY OR TOWN OF DEATH Trappe		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Green Nursing Home			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Ret. Waterman			12b. KIND OF BUSINESS OR INDUSTRY Seafood				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Talbot		13c. CITY OR TOWN Wittman		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER ----				
14. FATHER'S NAME John Bridges				15. MOTHER'S MAIDEN NAME Blizabeth Horney								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No				16b. SOCIAL SECURITY NO. 216-54-9413 T		17. INFORMANT Address Montgomery Thomas, Wittman, Maryland						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1538 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Retrospective Cardiac Vascular Disease</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>1 yr.</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 yr.												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State								
22a. I certify that (I) (this hospital) attended the deceased from Summer, 1956 to June 6, 1969, that (I) (we) last saw the deceased alive on June 6, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <i>R. Lane Wroth, M.D.</i>		DEGREE M.D.		ATTENDING PHYS. <input type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 6-7-69		
22d. PHYSICIAN'S NAME (Type) R. LANE WROTH, M.D.		22e. ADDRESS St. Michaels, Maryland										
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE June 8, 1969		23c. NAME OF CEMETERY OR CREMATORY Sherwood Cemetery			23d. LOCATION (City or Town) (County) (State) Sherwood, Maryland					
24. FUNERAL DIRECTOR <i>Samuel E. Leonard</i>		ADDRESS St. Michaels, Md.		25a. REC'D BY REGISTRAR DATE JUN 10 1969		25b. REGISTRAR'S SIGNATURE <i>Charles J. Jones</i>						

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08977

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

08969

1. DECEASED-NAME (Type or print) <i>JAMES Fletcher Burns</i>			2a. DATE OF DEATH Month <i>6</i> Day <i>22</i> Year <i>69</i>			2b. HOUR <i>1:35</i> P.M.					
3. SEX <i>MALE</i>		4. RACE <i>WHITE</i>		5. DATE OF BIRTH <i>NOV. 9 - 1902</i>		6. AGE (In years last birthday) <i>66</i> YRS.		IF UNDER 1 YEAR MONTHS <i></i> DAYS <i></i>		IF UNDER 1 YEAR HOURS <i></i> MIN. <i></i>	
7a. BIRTHPLACE (State or foreign country) <i>MARYLAND</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Ta/60t</i> Md.					
10. CITY OR TOWN OF DEATH <i>Easton</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Memorial</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>WATERMAN</i>			12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>MD.</i>			13b. COUNTY <i>G.A.</i>		13c. CITY OR TOWN <i>CHESTER</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER		
14. FATHER'S NAME First Middle Last <i>JAMES BURNS</i>			15. MOTHER'S MAIDEN NAME First Middle Last <i>ELVA HORNEY</i>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <i>No</i> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address <i>MRS. BURNS - CHESTER, MARYLAND</i>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral vascular accident</i> <i>4369</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>6 days</i>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <i>6-17</i> , 19 <i>69</i> , to <i>6-22</i> , 19 <i>69</i> , that (I) ( <del>we</del> ) last saw the deceased alive on <i>6-22</i> , 19 <i>69</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) ( <del>we</del> ) ( <del>did</del> ) ( <del>did not</del> ) view the body after death.											
22b. SIGNATURE <i>Stephen P. Carney</i> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>						22c. DATE SIGNED <i>6-23-69</i>					
22d. PHYSICIAN'S NAME (Type) <i>Stephen P. Carney</i>			M.D. <i>M.D.</i>			22e. ADDRESS <i>Easton, Maryland 21601</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <i>JUNE 25, 1969</i>		23c. NAME OF CEMETERY OR CREMATORY <i>STEVENSVILLE</i>			23d. LOCATION (City or Town) (County) (State) <i>STEVENSVILLE MD.</i>				
24. FUNERAL DIRECTOR <i>Lane Funeral Home Chuck Hill Md.</i>						25a. REC'D BY REGISTRAR DATE <i>JUN 27 1969</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

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08978										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										08970									
Item 13 Film 413 6/11/69 kk										CERTIFICATE OF DEATH																			
1. DECEASED-NAME (Type or print) <i>A</i>					First Middle Last <i>Carl Calloway</i>					2a. DATE OF DEATH Month Day Year <i>6 5 1969</i>					2b. HOUR <i>3:30</i> M.														
3. SEX <i>MALE</i>					4. RACE <i>WHITE</i>					5. DATE OF BIRTH <i>10-1-99</i>					6. AGE (In years last birthday) <i>71</i> YRS.					IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.									
7a. BIRTHPLACE (State or foreign country) <i>Md.</i>					7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>					8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					9. COUNTY OF DEATH <i>TALBOT</i>					Md.									
10. CITY OR TOWN OF DEATH <i>EASTON</i>					11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>HOUSE IN THE PINES</i>					12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>farmer</i>					12b. KIND OF BUSINESS OR INDUSTRY														
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md.</i>					13b. COUNTY <i>Talbot</i>					13c. CITY OR TOWN <i>Cordova</i>					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					13e. STREET AND NUMBER									
14. FATHER'S NAME First Middle Last <i>Josiah J. Calloway</i>					15. MOTHER'S MAIDEN NAME First Middle Last <i>Jennie Smoot</i>																								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>no</i>					16b. SOCIAL SECURITY NO. (If yes give war or dates of service) <i>219-14-4056</i>					17. INFORMANT Address <i>Charles B. Hickson, RFD Easton, Md. 21601</i>																			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>5901 Uremia</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Chronic pyelonephritis</i> DUE TO, OR AS A CONSEQUENCE OF (c)															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Uncertain</i>														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>Arteriosclerotic heart disease with congestive heart failure</i>																													
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>					20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?														
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>					21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work					21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)					21f. LOCATION Street or R.F.D. No. City or Town County State																			
22a. I certify that (I) (this hospital) attended the deceased from <i>4-20</i> , 19 <i>69</i> , to <i>6-5</i> , 19 <i>69</i> , that (I) (we) lost saw the deceased alive on <i>5-29</i> , 19 <i>69</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																													
22b. SIGNATURE <i>Robert W. Trever, M.D.</i>										DEGREE <i>MD.</i>					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					22c. DATE SIGNED <i>6-6-69</i>									
22d. PHYSICIAN'S NAME (Type)										22e. ADDRESS																			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>burial</i>					23b. DATE <i>6/7/69</i>					23c. NAME OF CEMETERY OR CREMATORY <i>Greenmount</i>					23d. LOCATION (City or Town) (County) (State) <i>Hillsboro Md.</i>														
24. FUNERAL DIRECTOR <i>Jay D. Haverin, Easton, Md.</i>										25a. REC'D BY REGISTRAR <i>DAVIN</i>					25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>														

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DEPARTMENT OF DEFENSE

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08979

## CERTIFICATE OF DEATH

08971

1. DECEASED-NAME (Type or print) <i>Fannie Messix Collins</i>			2a. DATE OF DEATH <i>6</i> Month <i>16</i> Day <i>1969</i> Year			2b. HOUR M			
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>1/18/1896</i>		6. AGE (In years lost birthday) <i>73</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <i>Md.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Talbot</i>			
1d. CITY OR TOWN OF DEATH <i>Easton</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>107 Goldsboro Street</i>		12a. USUAL OCCUPATION (Kind of work done during last year, even if retired.) <i>Housework</i>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased admission) STATE <i>Md.</i>		13b. COUNTY <i>Talbot</i>		13c. CITY OR TOWN <i>Easton</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>107 Goldsboro Street</i>	
14. FATHER'S NAME First Middle Last <i>John H. Messix</i>			15. MOTHER'S MAIDEN NAME First Middle Last <i>Margaret G. Dulin</i>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) <i>no</i>		16b. SOCIAL SECURITY NO. <i>213-22-8582 D.</i>		17. INFORMANT Address <i>Mrs. Henry H. Purdy, Easton, Md.</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of the stomach</i> <i>1519</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>6 mo.</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <i>April</i> , 19 <i>69</i> , to <i>6 June</i> , 19 <i>69</i> , that (I) ( <del>we</del> ) last saw the deceased alive on <i>14 June</i> , 19 <i>69</i> , and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above, (I) ( <del>we</del> ) (did) ( <del>did not</del> ) view the body after death.									
22b. SIGNATURE <i>Stephen P. Carney</i>					DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>6-17-69</i>		
22d. PHYSICIAN'S NAME (Type) <i>Stephen P. Carney, M.D.</i>					22e. ADDRESS <i>P.O. Box 929, Easton, Md. 21601</i>				
23a. BURIAL, CREMATION, etc. (Specify)		23b. DATE <i>6/18/1969</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Spring Hill</i>		23d. LOCATION (City or Town) (County) (State) <i>Easton, Md.</i>			
24. FUNERAL DIRECTOR <i>MURPHY E. NEUNAM &amp; SON, Easton, Md.</i>					25a. REC'D BY REGISTRAR <i>JUN 19 1969</i>		25b. REGISTRAR'S SIGNATURE <i>Charles J. Jones</i>		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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CERTIFICATE OF DEATH

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08980

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

08972

1. DECEASED-NAME (Type or print) <i>MARGARET M DAVIS</i>			2a. DATE OF DEATH Month <i>6</i> Day <i>19</i> Year <i>1969</i>			2b. HOUR <i>4:30 A M</i>	
3. SEX <i>F</i>		4. RACE <i>W.</i>		5. DATE OF BIRTH <i>10-6-1870</i>		6. AGE (In years lost birthday) <i>98</i> YRS.	
7a. BIRTHPLACE (State or foreign country) <i>MARYLAND</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>TALBOT</i>	
10. CITY OR TOWN OF DEATH <i>EASTON</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>307 S. WASHINGTON ST</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>RETIRED</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>HOUSEKEEPER</i>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>MD</i>		13b. COUNTY <i>TALBOT</i>		13c. CITY OR TOWN <i>EASTON</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER <i>307 S. WASHINGTON</i>		14. FATHER'S NAME First Middle Last <i>W M GREENWOOD</i>		15. MOTHER'S MAIDEN NAME First Middle Last <i>MARGARET MADDOX</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no (If unknown) <i>N</i>		16b. SOCIAL SECURITY NO. <i>217-30-872</i>		17. INFORMANT <i>JAMES C DAVIS</i>		Address <i>EASTON MD</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Heart Failure</i> <i>4123</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (b) <i>U.S. H. D.</i> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>weeks</i> <i>4 YRS.</i>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <i>May 19, 1969</i> to <i>June 17, 1969</i> , that (I) (we) lost the deceased alive on <i>May 19, 1969</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>S. KRECH, JR.</i>		DEGREE <i>MD</i>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>6/17/69</i>	
22d. PHYSICIAN'S NAME (Type) <i>S. KRECH, JR.</i>		22e. ADDRESS <i>EASTON, MD</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <i>6-19-69</i>		23c. NAME OF CEMETERY OR CREMATORY <i>SPRING HILL</i>		23d. LOCATION (City or Town) (County) (State) <i>EASTON TALBOT MD</i>	
24. FUNERAL DIRECTOR <i>[Signature]</i>		ADDRESS <i>[Signature]</i>		25a. REC'D BY REGISTRAR DATE <i>JUN 19 1969</i>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

MEDICAL CERTIFICATION

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DEPARTMENT OF DEATH

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED

DATE 10/10/00 BY 60322



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (7-64)  
45M - 1-69

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
08981										
08973										
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR		
Lula Rebecca Dill						6- 9- 69		10:5		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years lost birthday)		IF UNDER 1 YEAR		
female		while		11-28-89		79 YRS.		MONTHS DAYS		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Dorchester Co. Md.		U.S.A.				Talbot Md.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
Easton			House in The Pines			retired Milliner		Own business		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER	
Maryland			Caroline		Federalsburg		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		Reliance Avenue	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME							
First Middle Last			First Middle Last							
Dicen			Bradley			Rebecca Cannon				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address					
Yes, no, or unknown			Unknown		Mrs. Louise W. Longaker, Newport News, Va.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										
PART 1. DEATH WAS CAUSED BY:										
IMMEDIATE CAUSE (a) <i>Cause of the heart</i>										
DUE TO, OR AS A CONSEQUENCE OF										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										
(b) _____										
DUE TO, OR AS A CONSEQUENCE OF										
(c) _____										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
6 mths										
MEDICAL CERTIFICATION										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
					YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)						
		HOUR A.M. Month Day Year								
		P.M. 19								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION		Street or R.F.D. No.		City or Town County State		
22a. I certify that (I) (this hospital) attended the deceased from <i>12-16</i> , 19 <i>68</i> , to <i>6-9</i> , 19 <i>69</i> , that (I) (we) last saw the deceased alive on <i>6-4</i> , 19 <i>69</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE					DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED	
<i>Hyatt B. Caff</i>									6-9-69	
22d. PHYSICIAN'S NAME (Type)					22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Burial		June 11, 1969		Hill Crest		Federalsburg, Caroline, Md.				
24. FUNERAL DIRECTOR					25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
<i>J. F. Hampton &amp; Son</i>					Federalsburg, Md.		<i>Charles Judge</i>			
					DATE		JUN 13 1969			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the medical director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

08982

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08974

1. DECEASED-NAME (Type or print) First Middle Last <b>MARY HARRISON Donaldson</b>			2a. DATE OF DEATH Month <b>6</b> Day <b>29</b> Year <b>69</b>		2b. HOUR <b>8 A</b> M
3. SEX <b>FEMALE</b>	4. RACE <b>White</b>	5. DATE OF BIRTH <b>MARCH 1, 1893</b>		6. AGE (In years last birthday) <b>76</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (State or foreign country) <b>PENNSYLVANIA</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <b>Talbot</b> Md.		
10. CITY OR TOWN OF DEATH <b>Easton</b>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Bloomfield</b>	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>wife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>	13b. COUNTY <b>Talbot</b>	13c. CITY OR TOWN <b>Easton</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER <b>"Bloomfield"</b>	
14. FATHER'S NAME First Middle Last <b>Archibald Cunningham HARRISON</b>		15. MOTHER'S MAIDEN NAME First Middle Last <b>ANNA - WARFIELD</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <b>216-46-1540</b>	17. INFORMANT <b>SON, Thomas Donaldson, Jr., Baltimore, Md.</b> Address <b>8023 RIDER AVE.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral aneurysm accident</b> <b>436.9</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Immediate</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19 <b>68</b> , to <b>29 JUNE 1969</b> , that (I) (we) last saw the deceased alive on <b>28 June 1969</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Stephen P. Carney</b>		DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>6-30-69</b>	
22d. PHYSICIAN'S NAME (Type) <b>STEPHEN P. CARNEY</b>		22e. ADDRESS <b>EASTON, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>	23b. DATE <b>July 1, 1969</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Crematory</b>		23d. LOCATION (City or Town) (County) (State) <b>Washington D.C.</b>	
24. FUNERAL DIRECTOR <b>James H. Bunting - Barton Box, Centerville, Md.</b>		ADDRESS		25a. REC'D BY REGISTRAR <b>JUL 2 1969</b>	25b. REGISTRAR'S SIGNATURE

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
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MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print) <b>EMMA</b>			First <b>MAY</b> Middle <b>DORAN</b> Last			2a. DATE OF DEATH Month <b>6</b> Day <b>20</b> Year <b>69</b>		2b. HOUR <b>6p</b> M		
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>JAN. 1, 1891</b>		6. AGE (In years last birthday) <b>78</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) <b>MD</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>TALBOT</b> Md.				
10. CITY OR TOWN OF DEATH <b>EASTON</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>MEMORIAL</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Post Office</b>		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MD</b>			13b. COUNTY <b>CROFTON</b>		13c. CITY OR TOWN <b>DENTON</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
14. FATHER'S NAME First <b>FRANK</b> Middle <b>WOOTERS</b> Last			15. MOTHER'S MAIDEN NAME First <b>CATHERINE</b> Middle <b>WALLS</b> Last							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>NO</b> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address <b>Mrs. WALTER DOWNES, DENTON MD.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Ventricular fibrillation</b> <b>4124</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>ASCVD &amp; ORGANELLS TOXICITY</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>Congestive heart failure</b>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State		
22a. I certify that (I) (this hospital) attended the deceased from <b>6-19</b> , 19 <b>69</b> , to <b>6-20</b> , 19 <b>69</b> , that (I) (we) lost the deceased alive on <b>6-20</b> , 19 <b>69</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>Dorsett D. Smith</b> DEGREE <b>MD</b>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED				
22d. PHYSICIAN'S NAME (Type) <b>Dorsett D. Smith, M.D.</b>				22e. ADDRESS						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <b>JUNE 24, 1969</b>		23c. NAME OF CEMETERY OR CREMATORY <b>DENTON</b>		23d. LOCATION (City or Town) <b>DENTON</b> (County) <b>COR</b> (State) <b>MD</b>				
24. FUNERAL DIRECTOR <b>Charles V. Moore</b>		ADDRESS <b>Denton, Md.</b>		25a. REC'D BY REGISTRAR <b>JUN 27 1969</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>				

58020

RECEIVED B. 1000



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
08984 CERTIFICATE OF DEATH 08976										
1. DECEASED-NAME (Type or print) First Middle Last <b>HARVEY BLBERT GANNON</b>					2a. DATE OF DEATH Month Day Year <b>June 30, 1969</b>			2b. HOUR <b>1 P. M.</b>		
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>February 2, 1907</b>		6. AGE (In years last birthday) <b>62</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Talbot County</b> Md.				
10. CITY OR TOWN OF DEATH <b>Newcomb</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>-----</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Carpenter</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Housing</b>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>			13b. COUNTY <b>Talbot</b>		13c. CITY OR TOWN <b>Newcomb</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>-----</b>	
14. FATHER'S NAME First Middle Last <b>Elbert Gannon</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Sue Spence</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <b>No</b>			16b. SOCIAL SECURITY NO. <b>220-28-0054</b>		17. INFORMANT Address <b>Mrs. Marie B. Gannon, Newcomb, Maryland</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b> <b>4109</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Heart Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>INSTANT</b> <b>YRS</b>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State <b>3113 56 6 30 69</b>						
22a. I certify that (I) (this hospital) attended the deceased from <b>6/30 1969</b> , to <b>6/30 1969</b> , that (I) (we) last saw the deceased alive on <b>6/30 1969</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>Shepherd</b>				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>7/1/69</b>				
22d. PHYSICIAN'S NAME (Type) <b>SHEPARD KRECH, M. D.</b>				22e. ADDRESS <b>Easton, Maryland</b>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>July 2, 1969</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Spring Hill Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Easton, Maryland</b>				
24. FUNERAL DIRECTOR <b>Hanson E. Leonard, St. Michael's, Md.</b>				25a. REC'D BY REGISTRAR DATE <b>JUL 3 1969</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>				

08881

CERTIFICATE OF DEATH

State of New York, County of Westchester

08881

June 20, 1969

Attest: I, \_\_\_\_\_

Notary Public

County of Westchester

State of New York

Notary Public

Westchester County

State of New York

Notary Public

Notary Public

Notary Public

Notary Public

Notary Public

Notary Public

Notary Public

Notary Public

Notary Public, State of New York

Notary Public

After my death, I am to be buried in the  
Cemetery of the Holy Trinity Church, New York City

0/10 of 1/10

Notary Public

Notary Public

Notary Public

Notary Public

Notary Public

Notary Public

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
45M - 1-69

08985

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08977

1. DECEASED-NAME (Type or print) <i>Lyda A. Gannon</i>			2a. DATE OF DEATH Month <i>JUNE</i> Day <i>30</i> Year <i>69</i>			2b. HOUR <i>8:14</i> M			
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>8/25/1893</i>		6. AGE (In years and birthday) <i>75</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <i>Md.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH <i>Talbot</i>			
10. CITY OR TOWN OF DEATH <i>Easton</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>28 S. Washington Street</i>		12a. USUAL OCCUPATION (Kind of work done during last 12 months, if work in life even if retired.) <i>Clerk Stationery Store</i>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md.</i>		13b. COUNTY <i>Talbot</i>		13c. CITY OR TOWN <i>Easton</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>28 S. Washington St.</i>	
14. FATHER'S NAME First <i>Rufus</i> Middle <i>McNeal</i> Last				15. MOTHER'S MAIDEN NAME First <i>Annie E.</i> Middle <i>McCracklen</i> Last					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>no</i>		16b. SOCIAL SECURITY NO. <i>218-16-5367</i>		17. INFORMANT Address <i>C. Robert Rowens, Easton, Md.</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac arrhythmia</i> <i>4123</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arteriosclerotic heart disease with coronary insufficiency</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>3/66</i>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Immediate</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (the hospital) attended the deceased from <i>February 7, 1965</i> , to <i>June</i> , 19 <i>69</i> , that (I) (we) lost saw the deceased alive on <i>24 June</i> , 19 <i>69</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Stephen P. Carney</i>				DEGREE <i>M.D.</i>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>7-1-69</i>	
22d. PHYSICIAN'S NAME (Type) <i>Stephen P. Carney, M.D.</i>				22e. ADDRESS <i>P.O. Box 929, Easton, Md. 21601</i>					
23a. BURIAL, CREMATION, BOWLING (Specify)		23b. DATE <i>7/2/1969</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Landing Neck</i>		23d. LOCATION (City or Town) (County) (State) <i>Easton, Md.</i>			
24. FUNERAL DIRECTOR <i>MURICE E. NEUNAM &amp; SON, Easton, Md.</i>				ADDRESS		25a. REC'D BY REGISTRAR <i>JUL 2 1969</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

08082

CHARTER OF DASH

08082

Public. (Person)

08082/1893

Public

Public

Public

21

21

St. J. Martin the Great (St. Martin's Day)

Public

St. J. Martin the Great (St. Martin's Day)

Public

Public

St. J. Martin the Great (St. Martin's Day)

21

Public

Public

Public

St. J. Martin the Great (St. Martin's Day)

Public

4409  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 151-1-69  
45M - 1-69

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
08986											
08978											
1. DECEASED-NAME (Type or print)		First		Middle		Last		2a. DATE OF DEATH		2b. HOUR	
Esther		R.		Haddaway		6		Month 5 Day 69		629 PM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
FEMALE		WHITE		JULY 22-1884		84 YRS.		MONTHS		DAYS	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
MARYLAND		USA				Talcott					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY					
Easton		Memorial		HOUSEWIFE		xx					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER			
MD.		G. A.		GRASONVILLE				xx			
14. FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME		First Middle Last	
SAMUEL		PENTZ		AMANDA		RIGGENS					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address			
No						DOROTHY PORTER-GRASONVILLE MD.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) <u>Pyrexia generalized arteriosclerosis</u>										5 yr	
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
(b) _____											
DUE TO, OR AS A CONSEQUENCE OF											
(c) _____											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
<u>Collapsed vertebrae 2 wks</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <u>July</u> , 19 <u>66</u> , to <u>6-5</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>6-5</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED					
<u>Stephen P. Carney</u>		M.D.		Easton, Maryland		6/6/69					
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS									
Stephen P. Carney		Easton, Maryland									
23a. BURIAL, CREMATION, or other disposal		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
BURIAL		JUNES		STEVENSVILLE		STEVENSVILLE MD.					
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Hans Funeral Home		Church Hill, Md.		JUN 10 1969		[Signature]					

08280

08280

UNITED STATES DEPARTMENT OF AGRICULTURE  
BUREAU OF PLANT INDUSTRY  
WASHINGTON, D. C.

TO THE DIRECTOR, BUREAU OF PLANT INDUSTRY  
WASHINGTON, D. C.

FROM THE DIRECTOR, BUREAU OF PLANT INDUSTRY  
WASHINGTON, D. C.

SUBJECT: [Illegible]

[Illegible text follows, appearing to be a memorandum or report.]

2/11

1

Very truly yours,  
[Illegible signature]



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)		First	Middle	Lost	2a. DATE OF DEATH Month Day Year		2b. HOUR	
SARAH H. HARDCASTLE					June 1, 1969		5:44 M	
3. SEX Female		4. RACE White		5. DATE OF BIRTH February 9, 1884		6. AGE (In years lost birthday) 85 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Talbot County Md.		
1d. CITY OR TOWN OF DEATH St. Michaels		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Rio Vista Nursing Home		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Unemployed		12b. KIND OF BUSINESS OR INDUSTRY ---		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Talbot		13c. CITY OR TOWN St. Michaels		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER Chestnut St.
14. FATHER'S NAME Richard L. Hardcastle		15. MOTHER'S MAIDEN NAME Henrietta Nicols						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No		16b. SOCIAL SECURITY NO. -----		17. INFORMANT Address Lockwood Hardcastle, Bozman, Maryland				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiac failure</u> 4124 DUE TO, OR AS A CONSEQUENCE OF (b) <u>atherosclerotic cardiac vasc.</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>severe Kyphosis, osteoporosis - generalized</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 mos.	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from 1952, 19, to 6-1, 1969, that (I) (we) last saw the deceased alive on 6-1, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.								
22b. SIGNATURE <u>Guy M. Reiser, Jr.</u> MD		22c. DATE SIGNED 6-3-69		22d. PHYSICIAN'S NAME (Type) GUY M. REISER, Jr., M. D. St. Michaels, Maryland				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE June 3, 1969		23c. NAME OF CEMETERY OR CREMATORY Spring Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Easton, Maryland		
24. FUNERAL DIRECTOR Harrison E. Lerner, St. Michaels, Md.		25a. REC'D BY REGISTRAR JUN 4 1969		25b. REGISTRAR'S SIGNATURE <u>William J. [unclear]</u>				

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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08988

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08980

1. DECEASED-NAME (Type or print) First Middle Last <i>Mary Magdelin Harris</i>			2a. DATE OF DEATH Month Day Year <i>June 20 1969</i>			2b. HOUR M <i>135</i>					
3. SEX <i>Female</i>		4. RACE <i>Negro</i>		5. DATE OF BIRTH <i>June 25, 1903</i>		6. AGE (In years last birthday) <i>65</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		IF UNDER 24 HRS.	
7a. BIRTHPLACE (State or foreign country) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH <i>talbot</i> Md.					
10. CITY OR TOWN OF DEATH <i>Easton</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Newtown</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Laborer</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>None</i>					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Maryland</i>		13b. COUNTY <i>Talbot</i>		13c. CITY OR TOWN <i>St Michaels</i>		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET AND NUMBER <i>123 Freemont Street</i>			
14. FATHER'S NAME First Middle Last <i>William Harris</i>			15. MOTHER'S MAIDEN NAME First Middle Last <i>Mary Griffin</i>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>no</i> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <i>216-18-8958</i>		17. INFORMANT <i>Catherine Downes St. Michaels, Md.</i> Address							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Chronic active hepatitis</i> <i>7341</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Systemic lupus erythematosus</i> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>8 months</i> <i>5 weeks</i>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>alcoholism</i>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <i>5-21-1969</i> , to <i>6-20-1969</i> , that (I) (we) last saw the deceased alive on <i>6-19-1969</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Stephen P. Carney</i>				DEGREE <i>M.D.</i>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>6-21-69</i>			
22d. PHYSICIAN'S NAME (Type) <i>Stephen P. Carney, M. D.</i>				22e. ADDRESS <i>Easton, Maryland 21601</i>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>June 24 '69</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Newtown Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Newtown talbot Maryland</i>					
24. FUNERAL DIRECTOR <i>J.B. Dashiell 426 Dore St</i>				ADDRESS <i>Easton Md.</i>		25a. REC'D BY REGISTRAR <i>JUN 25 1969</i>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

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Stephen J. Evans, M.D.

Swanton, Vermont

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print) <i>Hughes Woodrow Harrison, Jr.</i>					2a. DATE OF DEATH Month <i>June</i> Day <i>27</i> Year <i>1969</i>			2b. HOUR <i>2:14</i> M	
3. SEX <i>M</i>		4. RACE <i>W</i>		5. DATE OF BIRTH <i>2/21/1913</i>		6. AGE (In years last birthday) <i>56</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <i>Md.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Talbot</i>			
10. CITY OR TOWN OF DEATH <i>Easton</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Memorial</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Farmer</i>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md.</i>		13b. COUNTY <i>Talbot</i>		13c. CITY OR TOWN <i>RFD</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
14. FATHER'S NAME First Middle Last <i>Douglas Harrison</i>					15. MOTHER'S MAIDEN NAME First Middle Last <i>Leona Burrows</i>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <i>no</i>		16b. SOCIAL SECURITY NO. <i>215-12-6110</i>		17. INFORMANT Address <i>Mrs. Miriam K. Harrison, RFD Box 98 Cordova</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Concussion of the lung</i> <i>1621</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>7 months</i>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>Pulmonary cell sarcoma</i>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <i>Nov</i> , 19 <i>68</i> , to <i>27 June</i> , 19 <i>69</i> , that (I) (we) last saw the deceased alive on <i>26 June</i> , 19 <i>69</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Stephen P. Carney</i> DEGREE <i>Stephen P. Carney, M.D.</i>					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>6-27-69</i>		
22d. PHYSICIAN'S NAME (Type) <i>Stephen P. Carney, M.D.</i>					22e. ADDRESS <i>Easton, Maryland 21601</i>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>burial</i>		23b. DATE <i>6/30/69</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Spring Hill</i>		23d. LOCATION (City or Town) (County) (State) <i>Easton, Talbot, Md.</i>			
24. FUNERAL DIRECTOR ADDRESS <i>Jay D. Haverin, Easton, Md.</i>					25a. REC'D BY REGISTRAR DATE <i>JUN 30 1969</i>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>		

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**FOR STATE  
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

08990

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

08982

1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH			2b. HOUR		
ERNEST			F. HUFFER			Month Day Year 6 1 1969			5:25		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years)	IF UNDER 1 YEAR		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD			2d. HOUR
M	W	JUNE 17, 1899	69	MONTHS	DAYS	HOURS	MIN.	Month Day Year			M
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			Md.		
MARYLAND		U.S.A.					TALBOT				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
EASTON			MEMORIAL HOSP.			RETIRED CARETAKER					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?		
DEL			NEW CASTLE			TOWNSEND			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			13e. STREET AND NUMBER			13f. STREET AND NUMBER		
CLARENCE F. HUFFER			ALICE VIRGINIA KELLFAVER			RURAL					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS		
NO			217-30-8451			MRS. VIOLET HUFFER			TOWNSEND, DEL.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) CORONARY OCCLUSION											
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
(b) ASCHD											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?			
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
			HOUR A.M. P.M. 19								
21d. INJURY OCCURRED		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.				City or Town		County State	
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>											
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE			CHIEF MEDICAL EXAMINER			M.D. ASSISTANT MEDICAL EXAMINER			22b. DATE SIGNED		
EXAMINER'S NAME (Type)			acting DEPUTY MEDICAL EXAMINER			ADDRESS (Street, city, town, or county)			6-1-69		
Louis S. Welty											
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)	
BURIAL		6/4/69		KENNEDYVILLE CEM		KENNEDYVILLE		M.D.			
24. FUNERAL DIRECTOR				25a. REC'D BY REGISTRAR				25b. REGISTRAR'S SIGNATURE			
J. Lester Daniels - Middletown, Del				JUN 4 1969				J. Charles Judge			



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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

08991		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				08983			
1. DECEASED-NAME (Type or print) First Middle Last Ethel Tilghman Ireland.						2a. DATE OF DEATH Month Day Year June 2 1969		2b. HOUR 10:55 PM	
3. SEX female		4. RACE white		5. DATE OF BIRTH 12-31-10		6. AGE (In years lost birthday) 58 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) VA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Talbot Md.			
10. CITY OR TOWN OF DEATH Easton		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Memorial Hosp.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) HOUSEWORK		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE MD		13b. COUNTY TALBOT		13c. CITY OR TOWN EASTON		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER GLEBE ROAD	
14. FATHER'S NAME First Middle Last JAMES F. TILGHMAN				15. MOTHER'S MAIDEN NAME First Middle Last CORA JONES.					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 218-24-4532		17. INFORMANT Address SAMUEL J. IRELAND, SR., EASTON, MD					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 174X Hyperstatic pneumonia DUE TO, OR AS A CONSEQUENCE OF (b) Carcinoma of breast with metastases DUE TO, OR AS A CONSEQUENCE OF (c) spread metastases Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION 10/30/68		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Co of breast right		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 10/30, 19 68, to 6/2, 19 69, that (I) (we) last saw the deceased alive on 6/2 19 69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.									
22b. SIGNATURE J.T.B. Ambler				DEGREE M. D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 6/4/69	
22d. PHYSICIAN'S NAME (Type) J. T. B. AMBLER				22e. ADDRESS EASTON, MARYLAND 21601 6/4/69					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 6/5/1969		23c. NAME OF CEMETERY OR CREMATORY FAIRVIEW		23d. LOCATION (City or Town) (County) (State) CORDOVA MD			
24. FUNERAL DIRECTOR E. Newman-John				ADDRESS EASTON, Md.		25a. REC'D BY REGISTRAR JUN 6 1969		25b. REGISTRAR'S SIGNATURE Charles Judge	



**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

08993		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				08985	
1. DECEASED-NAME (Type or print)		First	Middle	Lost	2a. DATE OF DEATH		2b. HOUR
HARRY				KINNAMON	6 Month 25 Day 69 Year		2:30 PM
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS	IF UNDER 1 YEAR HOURS
Male	White		Dec. 22, 1895		73 YRS.		
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Maryland	U.S.A.			Talbot Md.			
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
Easton	Memorial Hospital		Retired Store Clerk				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER			
Maryland	Caroline	Greensboro		None			
14. FATHER'S NAME First Middle Last		15. MOTHER'S MAIDEN NAME First Middle Last					
Charles W. Kinnamon		Anna Dill					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT Address			
No		717-07-9046		Mildred Kinnamon Greensboro, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART 1. DEATH WAS CAUSED BY:							
IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u>							
DUE TO, OR AS A CONSEQUENCE OF (b) <u>ASCVD</u>							
DUE TO, OR AS A CONSEQUENCE OF (c) <u>LLC PNEUMONIA</u>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
<u>CONGESTION HT FAILURE</u>							
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <u>6/25/69</u> to <u>6/25/69</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>6/25/69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE		22c. DATE SIGNED					
<u>Dorsett D. Smith</u>		6/28/69					
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS					
Dorsett D. Smith M.D.		Easton, Maryland 21601					
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Cremation	6-30-69	Cedar Hill		Washington, D.C.			
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
J.E. Boulais		Greensboro, Md.		JUL 1 1969		Charles Judge	

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FOR STATE  
HEALTH DEPT.

Items 18&22a Film 415 MARYLAND STATE DEPARTMENT OF HEALTH  
8-1-69 08994 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08986

1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH			Month Day Year			2b. HOUR					
FRANK BAKER LEWIS						ESTIMATED <input checked="" type="checkbox"/> 6 16 1969						M					
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD					
Male		White		May 16, 1928		41 YRS.		MONTHS DAYS		HOURS MIN.		Month Day Year 19 M					
7a. BIRTHPLACE (State or foreign country)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH					
New Jersey				USA								Talbot County Md.					
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)				12b. KIND OF BUSINESS OR INDUSTRY					
Bozman				-----				Woodcarver									
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE				13b. COUNTY				13c. CITY OR TOWN				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
Maryland				Talbot				Bozman									
14. FATHER'S NAME						15. MOTHER'S MAIDEN NAME						First Middle Last					
George Fenn Lewis						Eva Baker											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)						16b. SOCIAL SECURITY NO.						17. INFORMANT ADDRESS					
Yes						WW II						136-22-2370 Mrs. Bthel M. Lewis, Bozman, Maryland					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 1. DEATH WAS CAUSED BY:												Hours					
IMMEDIATE CAUSE (a) Alcohol-Barbiturate synergism																	
DUE TO, OR AS A CONSEQUENCE OF																	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.																	
(b) DUE TO, OR AS A CONSEQUENCE OF																	
(c)																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																	
19a. DATE OF OPERATION						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>						21b. TIME OF INJURY Month, Day, Year						21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)					
						HOUR A.M. P.M. 19											
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>						21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)						21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																	
ACTUAL SIGNATURE						CHIEF MEDICAL EXAMINER <input type="checkbox"/>						22b. DATE SIGNED					
EXAMINER'S NAME (Type)						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>						6-17-69					
LOUIS S. WELTY, M. D.						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>											
						ADDRESS (Street, city, town, or county)											
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City or Town) (County) (State)					
Cremation				June 18, 1969				Pt. Lincoln Cemetery				Washington, D. C.					
24. FUNERAL DIRECTOR						25a. REC'D BY REGISTRAR						25b. REGISTRAR'S SIGNATURE					
Hanson E. Leonard St. Michaels Md.						DATE JUN 17 1969						Charles Judge					

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MD. 21201  
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 72 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 1b. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 1-13. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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UNITED STATES DEPARTMENT OF HEALTH

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UNITED STATES DEPARTMENT OF HEALTH

NAME		DATE	
ADDRESS		CITY	
STATE		COUNTY	
ZIP		FEDERAL ID	
PATIENT'S NAME		PATIENT'S AGE	
PATIENT'S SEX		PATIENT'S RACE	
PATIENT'S RELIGION		PATIENT'S OCCUPATION	
PATIENT'S EDUCATION		PATIENT'S MARITAL STATUS	
PATIENT'S SOCIAL SECURITY NUMBER		PATIENT'S MEDICAL HISTORY	
PATIENT'S CURRENT MEDICATIONS		PATIENT'S ALLERGIES	
PATIENT'S PHYSICAL EXAMINATION		PATIENT'S LABORATORY TESTS	
PATIENT'S TREATMENT PLAN		PATIENT'S FOLLOW-UP	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																				
08995						CERTIFICATE OF DEATH						08987								
1. DECEASED-NAME (Type or print) <i>Ralph Vincent Muldoon</i>						2a. DATE OF DEATH Month <i>6</i> - Day <i>26</i> - Year <i>69</i>						2b. HOUR <i>1 P. M.</i>								
3. SEX <i>Male</i>			4. RACE <i>White</i>			5. DATE OF BIRTH <i>September 16, 1885</i>			6. AGE (In years last birthday) <i>83</i> YRS.			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			IF UNDER 24 HRS. HOURS MIN.					
7a. BIRTHPLACE (State or foreign country) <i>NEW JERSEY</i>			7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <i>TALBOT</i> Md.											
10. CITY OR TOWN OF DEATH <i>EASTON</i>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Memorial Hospital</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Retired Doctor of Pharmacy</i>			12b. KIND OF BUSINESS OR INDUSTRY											
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>MARYLAND</i>			13b. COUNTY <i>QUEEN ANNES</i>			13c. CITY OR TOWN <i>CHESTER</i>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET AND NUMBER <i>HARBOR VIEW</i>								
14. FATHER'S NAME First <i>JAMES VINCENT</i> Middle <i>Muldoon</i> Last <i>Muldoon</i>			15. MOTHER'S MAIDEN NAME First <i>MARTHA J. PIERSALL</i> Middle <i>CROSSAN</i> Last <i>CROSSAN</i>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)						16b. SOCIAL SECURITY NO. <i>135-09-5099</i>			17. INFORMANT <i>DAUGHTER</i> Address <i>Mrs. F. William Tillinghast, QUEENSTOWN, Md.</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Post operative pneumonia</i> <i>153.0</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i>																				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <i>Acute cholecystitis, carcinoma of the right colon</i>																				
19a. DATE OF OPERATION <i>6-18-69</i>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Cholecystitis, Adenocarcinoma of right colon</i>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)														
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State														
22a. I certify that (I) (this hospital) attended the deceased from <i>April</i> , 1969, to <i>26 June</i> , 1969, that (I) (we) last saw the deceased alive on <i>6-25</i> , 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																				
22b. SIGNATURE <i>Stephen P. Carney</i>						DEGREE <i>M.D.</i> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>						22c. DATE SIGNED <i>6-26-69</i>								
22d. PHYSICIAN'S NAME (Type) <i>Stephen P. Carney, M. D.</i>						22e. ADDRESS <i>Easton, Maryland 21601</i>														
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>			23b. DATE <i>JUNE 28, 1969</i>			23c. NAME OF CEMETERY OR CREMATORY <i>Maplewood Cemetery</i>			23d. LOCATION (City or Town) (County) (State) <i>Freehold, Monmouth Co., N.J.</i>											
24. FUNERAL DIRECTOR <i>James A. Dalton</i>			ADDRESS <i>Centreville, Maryland</i>			25a. FILED BY REGISTRAR <i>JUL 1 1969</i>			25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>											

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STATE OF TEXAS

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Joseph H. Garmon, M. D.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08988

1. DECEASED NAME (Type or print) <b>A. McCoy</b>			First Middle Last			2. DATE OF DEATH Month Day Year <b>6 28 1969</b>			2b. HOUR <b>10<sup>00</sup> AM</b>		
3. SEX <b>MALE</b>			4. RACE <b>WHITE</b>			5. DATE OF BIRTH <b>8/15/1903</b>			6. AGE (In years last birthday) <b>65</b> YRS.		
7a. BIRTHPLACE (State or foreign country) <b>MD</b>			7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>Talbot</b> Md.		
10. CITY OR TOWN OF DEATH <b>Easton</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Memorial</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MD</b>			13b. COUNTY <b>TALBOT</b>			13c. CITY OR TOWN <b>ST. MICHAELS</b>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME <b>WALTER T. NEWNAM</b>			First Middle Last			15. MOTHER'S MAIDEN NAME <b>ANNIE C. NIBLETT</b>			First Middle Last		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, No or unknown) <b>No</b>			16b. SOCIAL SECURITY NO. <b>320-16-9898</b>			17. INFORMANT <b>MRS. L. McCoy NEWNAM, ST. MICHAELS, MD</b>			Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>cardiac failure</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>cor pulmonale</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>C &amp; P E</b>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>6 days</b>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>1953</b> , 19____, to <b>6-28-1969</b> , that (I) (we) last saw the deceased alive on <b>6-28-1969</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Raym Breese Jr MD</b>						22c. DATE SIGNED <b>6-30-69</b>			22d. PHYSICIAN'S NAME (Type) <b>Raym Breese Jr</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>			23b. DATE <b>7/1/1969</b>			23c. NAME OF CEMETERY OR CREMATORY <b>SPRING HILL</b>			23d. LOCATION (City or Town) (County) (State) <b>EASTON, MD</b>		
24. FUNERAL DIRECTOR <b>William E. Newnam &amp; Son Easton</b>						25a. REC'D BY REGISTRAR <b>JUL 2 1969</b>			25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		

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DEPARTMENT OF HEALTH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08989

# CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) <i>Genevieve Amelia O'Brian</i>			2a. DATE OF DEATH Month <i>June</i> Day <i>30</i> Year <i>1969</i>			2b. HOUR <i>05</i> M <i>16</i>			
3. SEX <i>F</i>		4. RACE <i>W</i>		5. DATE OF BIRTH <i>1-5-1886</i>		6. AGE (In years last birthday) <i>83</i> YRS.		IF UNDER 1 YEAR MONTHS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <i>DELAWARE</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Talbot</i>			Md.
10. CITY OR TOWN OF DEATH <i>Easton</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Memorial</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>MANAGER</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>HOME</i>			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>MARYLAND</i>		13b. COUNTY <i>TALBOT</i>		13c. CITY OR TOWN <i>EASTON</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>604 WAYSIDE AVE</i>	
14. FATHER'S NAME First <i>WILLIAM</i> Middle <i>MURPHY</i> Last <i>MURPHY</i>			15. MOTHER'S MAIDEN NAME First <i>SARAH</i> Middle <i>CANE</i> Last <i>CANE</i>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <i>NO</i> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <i>214-32-2465</i>		17. INFORMANT <i>MISS GENEVIEVE O'BRIAN</i>		Address <i>EASTON, MD</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>CAR COLLISION AT THE RECTORY</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>1541</i> (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>3XRS</i>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Harry W. Walsh</i>		22c. DATE SIGNED <i>6-2-69</i>		22d. PHYSICIAN'S NAME (Type) <i>Harry W. Walsh, M.D.</i>		22e. ADDRESS <i>Easton, Md. 21601</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY <i>ODD FELLOWS</i>		23d. LOCATION (City or Town) (County) (State) <i>MILFORD DEL</i>			
24. FUNERAL DIRECTOR <i>Easton Ind</i>		25a. REC'D BY REGISTRAR <i>JUL 7 1969</i>		25b. REGISTRAR'S SIGNATURE <i>Richard Judge</i>					

10000

CERTIFICATE OF DEATH

Name of Deceased	
Age	
Sex	
Date of Death	
Place of Death	
Cause of Death	
Signature of Physician	
Signature of Registrar	
Date of Registration	
Place of Registration	

# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-5. Pages 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										08990	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH			2b. HOUR		
Jerome Henry Plugge						Month Day Year			M		
3. SEX			4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		2c. DATE PRONOUNCED DEAD		
male			white		5/17/98		71 YRS.		Month Day Year		
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH		
NEB			USA						TALBOT		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
Easton			Memorial Hosp.			STORE KEEPER					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. INSIDE CITY LIMITS?			13e. STREET AND NUMBER		
MD			TALBOT CORDOVA			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME								
First Middle Last			First Middle Last								
HENRY R. PLUGGE			ROSA LENA M. HUNTEMAN								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes <input type="checkbox"/> or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS		
No			320-32-1226			MRS. JEROME H. PLUGGE			CORDOVA, MD		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Respiratory Insufficiency										1 HR	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) FAR ADV. CHR. OBSTR. PULM. EMBOLISM										YRS.	
(c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
Contusion Left Lung Pneumothorax Right											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)					
			HOUR A.M. P.M. 19								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No.			City or Town County State		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE			CHIEF MEDICAL EXAMINER			22b. DATE SIGNED					
EXAMINER'S NAME (Type)			ASSISTANT MEDICAL EXAMINER			6/25/69					
S. KRECH, JR.			DEPUTY MEDICAL EXAMINER								
			ADDRESS (Street, city, town, or county)								
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)			
BURIAL			6/28/1969		WOODLAWN MEMORIAL PARK			EASTON, MD			
24. FUNERAL DIRECTOR			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE					
MAURICE E. KENNAMER, JR.			DATE JUN 30 1969			Charles Judge					





FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

08999

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08991

1. DECEASED-NAME (Type or Print)		First	Middle	Lost	2a. DATE KNOWN OF DEATH		<input checked="" type="checkbox"/> Month	Day	Year	2b. HOUR
JOHN			WAITE	PRITCHETT	OF ESTI- MATED		<input type="checkbox"/> 6	18	69	3:20
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (In years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS		2c. DATE PRONOUNCED DEAD	
male	white	July 2, 1895		73 YRS.	MONTHS		DAYS	HOURS	MIN.	Month
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Virginia		USA		TALBOT					Md.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
Easton		Memorial Hospital				Retired Washington, D.C.		Police Officer		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)		13b. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER				
Maryland		Hurlock		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		R.F.D. (Beulah)				
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME						
First Middle Lost				First Middle Lost						
Malcolm Pritchett				Unknown						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS		
Yes				None		John W. Pritchett, Jr.,		Burtonsville, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY:										
IMMEDIATE CAUSE (a) CORONARY OCCLUSION										
DUE TO, OR AS A CONSEQUENCE OF										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										
DUE TO, OR AS A CONSEQUENCE OF										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
Chronic bronchitis										
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?		
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				21b. TIME OF INJURY Month, Day, Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
				HOUR A.M. P.M.						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE		Louis S. Welty				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED		
						M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		6-18-69		
EXAMINER'S NAME (Type)		Louis S. Welty				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		ADDRESS (Street, city, town, or county)		
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Burial		June 20, 1969		Junior Order Cemetery		Preston Caroline Md.				
24. FUNERAL DIRECTOR				ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
J.J. Frampton & Son, Federalburg, Maryland						JUN 25 1969		Charles Jones		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

09000		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				08992	
1. DECEASED NAME (Type or print) <i>George E Rowland</i>					2a. DATE OF DEATH 6 Month Day 1 Year 69		2b. HOUR 7:55 M
3. SEX Male	4. RACE Cau.		5. DATE OF BIRTH 7-24-1892		6. AGE (In years last birthday) 76 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Brooklyn N.Y.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Talbot Md.	
1d. CITY OR TOWN OF DEATH Easton		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Memorial Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Ret. against Ret.		12b. KIND OF BUSINESS OR INDUSTRY Black & Decker	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md		13b. COUNTY Talbot		13c. CITY OR TOWN Easton, Md.		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER Easton, d		14. FATHER'S NAME First Middle Last Isaac E. Rowland		15. MOTHER'S MAIDEN NAME First Middle Last Anna Louise Campman			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, Yes (unknown) (If yes give year or dates of service) W.W.I		16b. SOCIAL SECURITY NO. 212-03-5372		17. INFORMANT Address Mrs Grace R. Homberg 1504 Chapel Hill Drive			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute left ventricular failure</i> 4123 DUE TO, OR AS A CONSEQUENCE OF (b) <i>Chronic atherosclerotic heart disease</i> DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days (?)	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <i>30 June</i> , 1969, to <i>1 June</i> , 1969, that (I) ( <del>we</del> ) last saw the deceased alive on <i>31 May</i> , 1969, and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above, (I) ( <del>we</del> ) ( <del>did</del> ) view the body after death.							
22b. SIGNATURE <i>Thurston Harrison M.D.</i> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22c. DATE SIGNED <i>1 June 69</i>			
22d. PHYSICIAN'S NAME (Type) THURSTON HARRISON		22e. ADDRESS EASTON MARYLAND					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 6-4-1969		23c. NAME OF CEMETERY OR CREMATORY Moreland Park		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR <i>Lassahn Funeral Home &amp; Ting</i>		ADDRESS		25a. REC'D BY REGISTRAR JUN 6 1969		25b. REGISTRAR'S SIGNATURE <i>William J. Judge</i>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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09001

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08993

1. DECEASED-NAME (Type or print) <i>Howard William Short</i>			2a. DATE OF DEATH Month <i>6</i> Day <i>29</i> Year <i>69</i>		2b. HOUR M
3. SEX <i>Male</i>	4. RACE <i>White</i>	5. DATE OF BIRTH <i>5/7/1886</i>		6. AGE (In years last birthday) <i>83</i> YRS.	IF UNDER 1 YEAR MONTHS IF UNDER 24 HRS. DAYS HOURS MIN.
7a. BIRTHPLACE (State or foreign country) <i>md.</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <i>Talbot</i> Md.		
10. CITY OR TOWN OF DEATH <i>Trappe</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Farmer</i>	12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE <i>md.</i>		13b. COUNTY <i>Talbot</i>	13c. CITY OR TOWN <i>Trappe</i>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER
14. FATHER'S NAME First <i>Samuel</i> Middle <i>Short</i> Last <i>Short</i>		15. MOTHER'S MAIDEN NAME First <i>Bessie</i> Middle <i>Moore</i> Last <i>Short</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO.		17. INFORMANT <i>Miss Pauline Short, Trappe, Md.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial infarction</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>INSTANT</i>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <i>11/18</i> , 19 <i>68</i> , to <i>6/29</i> , 19 <i>69</i> , that (I) (we) last saw the deceased alive on <i>4/18</i> , 19 <i>69</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>W.E. Gunby M.D.</i>		22c. DATE SIGNED <i>1 JULY 69</i>		22d. PHYSICIAN'S NAME (Type) <i>W.E. GUNBY</i>	
22e. ADDRESS <i>CAMBRIDGE MD.</i>		22f. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <i>11/69</i>		23c. NAME OF CEMETERY OR CREMATORY <i>East New Market</i>	
23d. LOCATION (City or Town) County State <i>East New Market, Md.</i>		23e. REGISTRAR'S SIGNATURE <i>James Judge</i>			
24. FUNERAL DIRECTOR <i>Lute S. Hulbush</i>		24a. ADDRESS <i>East New Market</i>		24b. DATE <i>1969</i>	

MEDICAL CERTIFICATION

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09002  
Item 8 Film 413 6/19/69 kk

## CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) <b>MAY ABSON STEWART</b>			2a. DATE OF DEATH <b>June</b> Month <b>14</b> , Day <b>1969</b> Year			2b. HOUR M				
3. SEX <b>female</b>		4. RACE <b>white</b>		5. DATE OF BIRTH <b>June 7, 1874</b>		6. AGE (In years lost birthday) <b>95</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (State or foreign country) <b>Alabama</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Talbot</b> Md.				
10. CITY OR TOWN OF DEATH <b>rural Easton</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>R. D. #1, Box 77</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>housewife</b>			12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>			13b. COUNTY <b>Talbot</b>		13c. CITY OR TOWN <b>Easton</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
14. FATHER'S NAME First Middle Last <b>William M. Boswell</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Achsa Scott</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. <b>220-46-3166</b>		17. INFORMANT Address <b>Mrs. Lyman S. Perry "Cosey Point" Easton, Md.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>794X Prognosis similarity</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>many years</b>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <b>1950</b> , 19____, to <b>Present</b> , that (I) (we) last saw the deceased alive on <b>August 19</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>Stephen P. Carney</b>				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>6-15-69</b>				
22d. PHYSICIAN'S NAME (Type) <b>Dr. Stephen P. Carney</b>				22e. ADDRESS <b>Easton, Maryland</b>						
23a. BURIAL, CREMATION, or other disposition (Specify) <b>Burial</b>		23b. DATE <b>June 17, 1969</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Oak Hill</b>		23d. LOCATION (City or Town) (County) (State) <b>Lakeland, Polk, Florida</b>				
24. FUNERAL DIRECTOR <b>Maurice E. Neunam &amp; Son</b>				ADDRESS <b>Easton, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>JUN 17 1969</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 1 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 5 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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09003

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08995

1. DECEASED-NAME (Type or print) <u>Mia Angela Swartz</u>		2a. DATE OF DEATH 6 Month 5 Day 69 Year		2b. HOUR 11 P M	
3. SEX <u>FEMALE</u>		4. RACE <u>WHITE</u>		5. DATE OF BIRTH 6/5/1969	
7a. BIRTHPLACE (State or foreign country) <u>MD</u>		7b. CITIZEN OF WHAT COUNTRY?		6. AGE (In years last birthday) — YRS.	
10. CITY OR TOWN OF DEATH <u>Easton</u>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Chenue</u>		9. COUNTY OF DEATH <u>Talbot</u> Md.	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <u>Maryland</u>		13b. COUNTY <u>Talbot</u>		13c. CITY OR TOWN <u>Easton</u>	
14. FATHER'S NAME <u>JOHN E. SWARTZ</u>		15. MOTHER'S MAIDEN NAME <u>JEANNE M. LARRIMORE</u>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT <u>JOHN E. SWARTZ, EASTON, MD.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>777x</u> <u>70h</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>6-4</u> , 19 <u>69</u> , to <u>6-5</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>6-5</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Rane Wroth, MD</u>		22c. DATE SIGNED <u>6-6-69</u>		22d. PHYSICIAN'S NAME (Type) <u>R. Lane Wroth, M.D.</u>	
22e. ADDRESS <u>St. Michaels, Maryland</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>			
23b. DATE <u>6/9/1969</u>		23c. NAME OF CEMETERY OR CREMATORY <u>SPRING HILL</u>		23d. LOCATION (City or Town) (County) (State) <u>EASTON, MD</u>	
24. FUNERAL DIRECTOR <u>James E. Newnam + Don Saylor</u>		25a. REC'D BY REGISTRAR <u>JUN 10 1969</u>		25b. REGISTRAR'S SIGNATURE <u>Officer's Office</u>	

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OFFICE OF THE SECRETARY

UNITED STATES DEPARTMENT OF THE INTERIOR



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers - Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print) <b>Fannie Mae Tatman</b>			2a. DATE OF DEATH <b>6</b> Month <b>10</b> Day <b>69</b> Year <b>7<sup>20</sup></b> Hour <b>1<sup>20</sup></b> M			2b. HOUR			
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>May, 20, 1884</b>		6. AGE (In years last birthday) <b>85</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <b>Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Talbot</b>			
10. CITY OR TOWN OF DEATH <b>Easton</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Memorial Hospital</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Housework</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>		13b. COUNTY <b>Queen Anne's</b>		13c. CITY OR TOWN <b>Sudlersville</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>-----</b>	
14. FATHER'S NAME <b>Charles</b>			15. MOTHER'S MAIDEN NAME <b>Martha Pratt.</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>No.</b> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. <b>215-50-9273J1</b>		17. INFORMANT <b>Miss, Helen M. Tatman, Sudlersville, Md.</b>		Address <b>21668</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart Failure</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Acute Myocardial Infarction</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>AS + D</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>4109</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 da.</b> <b>5 da</b> <b>yrs.</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Diabetes Mellitus and Diabetic Acidosis</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>6/9</b> , 19 <b>69</b> , to <b>6/10</b> , 19 <b>69</b> , that (I) (we) last saw the deceased alive on <b>6/9</b> , 19 <b>69</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>S. Krech Jr</b>				DEGREE <b>PHYS.</b>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>6/10/69</b>	
22d. PHYSICIAN'S NAME (Type) <b>S. KRECH JR</b>				22e. ADDRESS <b>EASTON Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>June, 13, 1969</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Church Hill Cemetery.</b>		23d. LOCATION (City or Town) (County) (State) <b>Church Hill, Q.A. Md.</b>			
24. FUNERAL DIRECTOR <b>Edward Fellows Millington, Md.</b>				ADDRESS		25a. REC'D BY REGISTRAR <b>JUN 12 1969</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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09005		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				08997	
CERTIFICATE OF DEATH							
1. DECEASED-NAME (Type or print) First Middle Last <i>Alice Jones Taylor</i>			2a. DATE OF DEATH Month Day Year <i>June 18, 1969</i>			2b. HOUR 3 <sup>53</sup> A. M.	
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH <i>4-8-09</i>		6. AGE (In years lost birthday) <i>60</i> YRS.	
7a. BIRTHPLACE (State or foreign country) <i>N.Y.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>TALBOT</b> Md.	
10. CITY OR TOWN OF DEATH <b>EASTON</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>HOUSE IN THE PINES</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Housework</i>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <i>Md.</i>		13b. COUNTY <i>Talbot</i>		13c. CITY OR TOWN <i>Caston</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME First Middle Last <i>Sydney T. Jones</i>		15. MOTHER'S NAME First Middle Last <i>Guennola Smith</i>		13e. STREET AND NUMBER <i>514 Tripp Ave.,</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, <i>no</i> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <i>216-46-3059</i>		17. INFORMANT <i>Rev. George A. Taylor, Caston, Md.</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Chronic Congestive Heart Failure</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Rheumatic Heart Disease, Inactive</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>2 yrs</i> 398 X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 yrs</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 69		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <i>7/5</i> , 19 <i>68</i> , to <i>6/18</i> , 19 <i>69</i> that (I) (we) lost saw the deceased alive on <i>6/17</i> , 19 <i>68</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>S. KRECH</i>		22c. DATE SIGNED <i>6/15/69</i>		22d. PHYSICIAN'S NAME (Type) <i>S. KRECH JR.</i>			
22e. ADDRESS <i>EASTON</i>							
23a. BURIAL, CREMATION, or other disposition <i>Burial</i>		23b. DATE <i>6/20/1969</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Old St. Paul's</i>		23d. LOCATION (City or Town) (County) (State) <i>Chestertown, Md.</i>	
24. FUNERAL DIRECTOR <i>Maurice E. Newman &amp; Son</i>		ADDRESS <i>Easton, Md.</i>		25a. REC'D BY REGISTRAR <i>JUN 19 1969</i>		25b. REGISTRAR'S SIGNATURE <i>Williamas Judge</i>	

03002

CERTIFICATE OF DEATH

TO BE FILLED BY THE REGISTRAR OF DEATHS, OR BY A PERSON AUTHORIZED BY HIM IN WRITING

03002

Full Name of Deceased: [illegible] Date of Birth: [illegible]

Place of Birth: [illegible] Date of Death: [illegible]

Cause of Death: [illegible] Duration of Illness: [illegible]

Signature of Registrar: [illegible] Signature of Deceased: [illegible]

Signature of Medical Officer: [illegible] Signature of Family: [illegible]

Signature of Priest: [illegible] Signature of Burial: [illegible]

Signature of Coroner: [illegible] Signature of Inquest: [illegible]

Signature of Jury: [illegible] Signature of Verdict: [illegible]

Signature of Court: [illegible] Signature of Judgment: [illegible]

Signature of Appeal: [illegible] Signature of Final: [illegible]

Signature of Execution: [illegible] Signature of Sentence: [illegible]

Signature of Pardon: [illegible] Signature of Release: [illegible]

Signature of Commutation: [illegible] Signature of Reprieve: [illegible]

Signature of Respite: [illegible] Signature of Stay: [illegible]

Signature of Adjournment: [illegible] Signature of Continuance: [illegible]

Signature of Postponement: [illegible] Signature of Deferral: [illegible]

Signature of Extension: [illegible] Signature of Prolongation: [illegible]

Signature of Continuance: [illegible] Signature of Stay: [illegible]

Signature of Adjournment: [illegible] Signature of Continuance: [illegible]

Signature of Postponement: [illegible] Signature of Deferral: [illegible]

Signature of Extension: [illegible] Signature of Prolongation: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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09006

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08998

# CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) <b>MYRA</b> First <b>C</b> Middle <b>TAYLOR</b> Last			2a. DATE OF DEATH Month <b>6</b> Day <b>21</b> Year <b>69</b>			2b. HOUR <b>437</b> M	
3. SEX <b>Female</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH <b>August 18, 1908</b>		6. AGE (In years last birthday) <b>60</b> YRS.	
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>TAIBOT</b> Md.	
10. CITY OR TOWN OF DEATH <b>EASTON</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>MEMORIAL</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Public School teacher</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>School</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Caroline</b>		13c. CITY OR TOWN <b>Preston</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME First <b>James</b> Middle <b>R.</b> Last <b>Christopher</b>		15. MOTHER'S MAIDEN NAME First <b>Velma</b> Middle <b>Carroll</b> Last		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> NO <input checked="" type="checkbox"/> (If yes give war or dates of service)			
16b. SOCIAL SECURITY NO. <b>426-80-9107</b>		17. INFORMANT Address <b>Mrs. Velma C. Christopher, Preston, Md.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute myocardial infarction</b> <b>4109</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. _____ Month _____ Day _____ Year <b>19</b> P.M. _____		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work _____ at work _____		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. _____ City or Town _____ County _____ State _____			
22a. I certify that (I) (this hospital) attended the deceased from <b>6-17, 1969</b> to <b>6-21, 1969</b> , that (I) (we) last saw the deceased alive on <b>6-21</b> 19 <b>69</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Stephen P. Carney</b>		DEGREE <b>M.D.</b>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>6-23-69</b>	
22d. PHYSICIAN'S NAME (Type) <b>Stephen P. Carney</b>		22e. ADDRESS <b>Easton, Maryland 21601</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>June 25, 1969</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Junior Order Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Preston, Caroline Md.</b>	
24. FUNERAL DIRECTOR <b>J.J. Frampton &amp; Son, Federalsburg, Maryland</b>		ADDRESS		25a. REC'D BY REGISTRAR <b>JUN 30 1969</b>		25b. REGISTRAR'S SIGNATURE <b>Richard Judge</b>	



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1621

1621

1621

09007		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				08999	
CERTIFICATE OF DEATH							
1. DECEASED-NAME (Type or print) <i>Gough</i> First <i>Winn</i> Middle <i>Thompson</i> Last			2a. DATE OF DEATH Month <i>6</i> Day <i>9</i> Year <i>69</i>			2b. HOUR <i>1:20</i> M	
3. SEX <i>MALE</i>		4. RACE <i>WHITE</i>		5. DATE OF BIRTH <i>1/12/1898</i>		6. AGE (In years last birthday) <i>71</i> YRS.	
7a. BIRTHPLACE (State or foreign country) <i>MD</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>TALBOT</i> Md.	
10. CITY OR TOWN OF DEATH <i>EASTON</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Memoria 1</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>HORSE BREEDER</i>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>MD</i>		13b. COUNTY <i>TALBOT TRAPPE</i>		13c. CITY OR TOWN <i>ROSLYN FARM</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME First <i>Gough</i> Middle <i>Winn</i> Last <i>Thompson</i>			15. MOTHER'S MAIDEN NAME First <i>Katherine W.</i> Middle <i>Harrison</i> Last				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>YES</i>		16b. SOCIAL SECURITY NO. <i>216-14-3206</i>		17. INFORMANT <i>Mrs. Gough W. Thompson, Trappe, MD</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of lung</i> <i>1621</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>10 mos.</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. _____ P.M. _____ Month _____ Day _____ Year <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. _____ City or Town _____ County _____ State _____			
22a. I certify that (I) (this hospital) attended the deceased from <i>Sept</i> , 19 <i>69</i> , to <i>9 June</i> , 19 <i>69</i> , that (I) ( <del>we</del> ) last saw the deceased alive on <i>8 June</i> , 19 <i>69</i> , and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above, (I) ( <del>we</del> ) ( <del>did</del> ) ( <del>did not</del> ) view the body after death.							
22b. SIGNATURE <i>Maurice E. Newnam</i>		22c. DATE SIGNED <i>9 June 69</i>		22d. PHYSICIAN'S NAME (Type) <i>hurston Harrison</i>		22e. ADDRESS <i>Dutchman's Lane Easton, Md. 21601</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		23b. DATE <i>6/11/1969</i>		23c. NAME OF CEMETERY OR CREMATORY <i>ST. THOMAS CHURCH CEMETERY</i>		23d. LOCATION (City or Town) (County) (State) <i>GARRISON, MD</i>	
24. FUNERAL DIRECTOR <i>Maurice E. Newnam &amp; Son</i>		ADDRESS <i>Easton, Md</i>		25a. REC'D BY REGISTRAR <i>JUN 11 1969</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



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U.S. DEPT. OF AGRICULTURE  
WASHINGTON, D.C.

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U.S. DEPT. OF AGRICULTURE  
WASHINGTON, D.C.



FOR STATE  
HEALTH DEPT.

09008

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09000

1. DECEASED-NAME (Type or Print) <b>Darlene Williams</b>		2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> Month <b>6</b> Day <b>12</b> Year <b>1969</b>		2b. HOUR <b>8 PM</b>
3. SEX <b>Female</b>	4. RACE <b>Negro</b>	5. DATE OF BIRTH <b>Aug. 5, 1956</b>	6. AGE (In years last birthday) <b>12</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <b>Talbot</b>
10. CITY OR TOWN OF DEATH <b>Easton</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Memorial</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Student</b>
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) <b>Maryland</b>		13b. COUNTY <b>Talbot</b>	13c. CITY OR TOWN <b>Easton</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME First <b>John</b> Middle <b>Williams</b> Last <b>Williams</b>		15. MOTHER'S MAIDEN NAME First <b>Clara</b> Middle <b>Conyer</b> Last <b>Conyer</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16b. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Clara Williams</b> ADDRESS <b>Easton, Md. RFD#3, Glenwood Ave.</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Accidental drowning</b> <b>9109</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. TIME OF INJURY Month, Day, Year <b>CS HOUR AM P.M. 6-12 1969</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1, or Part 2, Item 18.) <b>Drowned in borrow pit</b>
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <b>In Easton</b>		21f. LOCATION Street or R.F.D. No. City or Town County State <b>Talbot Md</b>
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				
ACTUAL SIGNATURE <b>Dr. Louis S. Welty</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county) <b>actmy</b>		22b. DATE SIGNED <b>6-14-69</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>6/16/69</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Richards Memorial</b>	23d. LOCATION (City or Town) (County) (State) <b>Easton Talbot Maryland</b>	25a. REC'D BY REGISTRAR <b>J. B. Dashiell</b>
24. FUNERAL-DIRECTOR <b>J. B. Dashiell Funeral Home</b>		25b. REGISTRAR'S SIGNATURE <b>g Charles Judge</b>		25c. DATE <b>JUN 17 1969</b>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

20083

UNITED STATES DEPARTMENT OF JUSTICE

FEDERAL BUREAU OF INVESTIGATION

WASHINGTON, D. C. 20535

DATE: 10/10/83

TO: DIRECTOR, FBI

FROM: SAC, NEW YORK

SUBJECT: [Illegible]

RE: [Illegible]

1. [Illegible]

2. [Illegible]

3. [Illegible]

4. [Illegible]

5. [Illegible]

6. [Illegible]

7. [Illegible]

8. [Illegible]

9. [Illegible]

10. [Illegible]

11. [Illegible]

12. [Illegible]

13. [Illegible]

14. [Illegible]

15. [Illegible]

16. [Illegible]

17. [Illegible]

18. [Illegible]

19. [Illegible]

20. [Illegible]

21. [Illegible]

22. [Illegible]

23. [Illegible]

24. [Illegible]

25. [Illegible]

26. [Illegible]

27. [Illegible]

28. [Illegible]

29. [Illegible]

30. [Illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
45M - 1/69

09009		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				09001	
CERTIFICATE OF DEATH							
1. DECEASED-NAME (Type or print) First Middle Last ISAAC RICHARD WILSON			2a. DATE OF DEATH Month Day Year 6 1 69			2b. HOUR 7:40 P.M.	
3. SEX M		4. RACE W		5. DATE OF BIRTH OCT 15, 1880		6. AGE (In years last birthday) 88 YRS.	
7a. BIRTHPLACE (State or foreign country) M.S.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH TALBOT	
10. CITY OR TOWN OF DEATH Easton		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Memorial Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) FARM		12b. KIND OF BUSINESS OR INDUSTRY COUNTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD		13b. COUNTY DENTON		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
14. FATHER'S NAME First Middle Last RICHARD THOMAS WILSON			15. MOTHER'S MAIDEN NAME First Middle Last JENNIE CLARK				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No			16b. SOCIAL SECURITY NO.		17. INFORMANT RICHARD WILSON, DENTON MD		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MESENTERIC THROMBOSIS</u> 4124 DUE TO, OR AS A CONSEQUENCE OF <u>C.V.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>AS - D -</u> DUE TO, OR AS A CONSEQUENCE OF (c)						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 DAYS 70 YRS	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) LEFT CVA - 2 YRS AGO							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <u>5-30</u> , 19 <u>67</u> , to <u>6-1</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>5-31</u> , 19 <u>67</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE J. Knud-Hansen				DEGREE M.D.		22c. DATE SIGNED 6/2/69	
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS Easton, Maryland 21601			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE JUN 5 4, 1969		23c. NAME OF CEMETERY OR CREMATORY EGLINGTON		23d. LOCATION (City or Town) (County) (State) CHARLESBORO GLOU. N.S.	
24. FUNERAL DIRECTOR CHARLES V. MOORE DENTON MD.				25a. REC'D BY REGISTRAR JUN 4 1969		25b. REGISTRAR'S SIGNATURE Charles Judge	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 48 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
09010					09002				
1. DECEASED-NAME (Type or print) <i>Baby Bay Wright</i>					2a. DATE OF DEATH <i>June 28 1969</i>			2b. HOUR <i>4:40 AM</i>	
3. SEX <i>Male</i>		4. RACE <i>Col.</i>		5. DATE OF BIRTH <i>June 28, 1969</i>		6. AGE (In years last birthday) <i>-</i> YRS.		IF UNDER 1 YEAR: MONTHS <i>2</i> DAYS <i>2</i> IF UNDER 24 HRS. HOURS <i>2</i> MIN.	
7a. BIRTHPLACE (State or foreign country) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>TALBOT</i> Md.			
10. CITY OR TOWN OF DEATH <i>Easton</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Marshall</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>None</i>			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) <i>Maryland</i>		13b. COUNTY <i>Talbot</i>		13c. CITY OR TOWN <i>Greensboro</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <i>Rt. 2, Box 59</i>	
14. FATHER'S NAME First <i>Raymond</i> Middle <i>Burk</i> Last <i>Wright</i>		15. MOTHER'S MAIDEN NAME First <i>Sheene</i> Middle <i>Wright</i> Last <i>Wright</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT <i>Robert Wright Greensboro, Md.</i> Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral anoxemia</i> DUE TO, OR AS A CONSEQUENCE OF <i>Cord tightly about neck</i> (b) <i>Asphyxia</i> DUE TO, OR AS A CONSEQUENCE OF <i>Maternal anoxemia</i> (c) <i>Maternal anoxemia</i> CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <i>6/28 1969</i> , to <i>6/28 1969</i> , that (I) (we) last saw the deceased alive on <i>6/28/69</i> 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>E. D. Hardy</i>		22c. PHYSICIAN'S NAME (Type) <i>E. D. Hardy</i>		22d. ADDRESS <i>M.D. Easton, Maryland 21601</i>		22e. DATE SIGNED <i>7/2/69</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>July 1, 1969</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Union</i>		23d. LOCATION (City or Town) (County) (State) <i>Goldsboro, Md.</i>			
24. FUNERAL DIRECTOR <i>John S. Boulais</i>		24a. ADDRESS <i>Greensboro</i>		25a. REC'D BY REGISTRAR <i>JUL 7 1969</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			





1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A 5 (4)  
45M - 1-69

09011

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

09003

1. DECEASED-NAME (Type or print) <i>Anra</i> First <i>Mabel</i> Middle <i>Zaffere</i> Last			2a. DATE OF DEATH Month <i>6</i> Day <i>19</i> Year <i>69</i>			2b. HOUR <i>9</i> M					
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>October 16, 1894</i>		6. AGE (In years last birthday) <i>74</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Talbot</i> Md.					
10. CITY OR TOWN OF DEATH <i>Easton</i>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Memorial</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Housework</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Maryland</i>			13b. COUNTY <i>Caroline</i>		13c. CITY OR TOWN <i>Federalsburg</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>West Central Avenue</i>		
14. FATHER'S NAME First <i>Isaac</i> Middle Last <i>Huhn</i>			15. MOTHER'S MAIDEN NAME First <i>Elizabeth</i> Middle Last <i>White</i>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <i>No</i>			16b. SOCIAL SECURITY NO.		17. INFORMANT Address <i>Mrs. John Orban, Federalsburg, Maryland</i>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>RUPTURED DIVERTICULUM COLON</i> <i>5621</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____ 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Harry M. Walsh</i>			DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED					
22d. PHYSICIAN'S NAME (Type) <i>Harry M. Walsh, M.D.</i>			22e. ADDRESS <i>Easton, Md. 21601</i>								
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>June 23, 1969</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Hill Crest Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Federalsburg, Caroline, Md.</i>					
24. FUNERAL DIRECTOR <i>J. J. Hampton</i>			ADDRESS <i>1801 Federalby Md.</i>			25a. REC'D BY REGISTRAR <i>JUN 25 1969</i>		25b. REGISTRAR'S SIGNATURE <i>Atlanta Judge</i>			

50000

STATE OF TEXAS

11000

London, No. 1000

Harry H. Fisher, N.D.